	timesicine a mesic	T SERVICES					10 1101 0700 0071
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			COMPLETED		
155501			B. WING			04/07/2011	
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
					LANCASTER ST		
MEADO\	WVALE HEALTH AI	ND REHABILITATION CENTER		BLUFF	TON, IN46714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AIE	DATE
K0000							
	A Life Safety C	ode Recertification	K0	000			
	and State Licer	nsure Survey was					
	conducted by	the Indiana State					
	Department of						
	l -						
	accordance wi	th 42 CFR 483.70(a).					
	Survey Date: (	04/07/11					
	-						
	   Facility Numbe	or: 00046E					
	l ,						
	Provider Number: 155501						
	AIM Number: 100273870						
	Surveyor: Amy	v Kellev Tife Safety					
	Surveyor: Amy Kelley, Life Safety						
	Code Specialis	· C					
	At this Life Saf	fety Code survey,					
	Meadowvale H	ealth and					
	Rehabilitation Center was found						
	not in complia						
	Requirements	for Participation in					
	Medicare/Med	icaid, 42 CFR					
	Subpart 483.7	0(a), Life Safety					
	I	the 2000 edition of					
	the National Fi						
	Association (N	FPA) 101, Life Safety					
	Code (LSC), Chapter 19, Existing						
	Health Care Occupancies and 410						
	IAC 16.2.						
	1AC 10.2.						
	This one story	facility was					
	determined to	be of Type V (111)					
	construction a						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5TFL21

Facility ID:

000465

If continuation sheet

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	OVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		DENTIFICATION NUMBER:		DING	01	COMPLETED	
		155501	B. WING			04/07/2	011
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					LANCASTER ST		
MEADOWVALE HEALTH AND REHABILITATION CENTER					TON, IN46714		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ne facility has a fire					
	alarm system w						
	detection in the	e corridors and					
	areas open to t	he corridors. The					
	facility has a ca	pacity of 120 and					
	had a census o	f 68 at the time of					
	this survey.						
	Quality Review by I	Robert Booher, REHS, Life					
		ist-Medical Surveyor on					
	04/12/11.						
	The facility was found not in						
	compliance wit	h the					
	aforementioned						
		· ·					
	requirements as evidenced by the						
following:							
120025	Smoko barriore ar	e constructed to provide at					
K0025		our fire resistance rating in					
		3.3. Smoke barriers may					
		rium wall. Windows are					
	protected by fire-rated glazing or by wired						
		steel frames. A minimum of					
		partments are provided on					
		ers are not required in duct noke barriers in fully ducted					
		g, and air conditioning					
		7.3, 19.3.7.5, 19.1.6.3,					
	19.1.6.4						
SS=E	Based on obser	vation and	K0	025	K – 025		05/23/2011
	interview, the f	acility failed to				,	
	ensure 1 of 1 c	•			It is the practice of this facility assure that all miscellaneous I		
		aintained to provide			safety issues are within		
		hour fire resistance			compliance at all times to inclu	ıde:	
					The Maintenance Supervise		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	A. BUIL	DING	NSTRUCTION  01	(X3) DATE S COMPL <b>04/07/2</b>	ETED
NAME OF PROVIDER OR SUPPLIER  MEADOWVALE HEALTH AND REHABILITATION CENTER			B. WING 04/07/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  1529 W LANCASTER ST  BLUFFTON, IN46714				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	barriers shall be an outside wall. This deficient pany residents in hall and at the station in the elemergency.  Findings include Based on an obeography Maintenance Displayed on an obeography of the Maintenance of penetration in the fire doors near where new commun. Measurement by the Maintenance of observation of the Maintenance of the Mai	e: eservation with the frector on 45 p.m., there is a furth inch unsealed the ceiling at the fresident room 502 figurer lines were finents were provided fance Director at the fation.			will patch the one and one four inch unsealed penetration in the ceiling at the fire doors near resident room 502 with a fire retardant sealant. 2. An aud was conducted by the Maintenance Supervisor to identify and repair any smoke barriers to ensure there will be continuous form from outside to an outside wall. 3. The Maintenance Supervisor was in-serviced on April 14, 2011 of Life Safety Tag K025 to identify unsealed penetration in the ceilings of the facility. 4. An audit will be conducted by the Maintenance Supervisor on a monthly basis in order to identify unsealed penetrations. It also be monitored through the facility's Performance Improvement Program for furth recommendations and resolutions.	it vall n y	
K0038		anged so that exits are at all times in accordance 19.2.1					
SS=E	Based on obser interview, the f ensure 1 of 8 e		K0	038	<b>K – 038</b> It is the practice of this facility to assure that all miscellaneous life safety issue		05/23/2011

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILI	DING	01	COMPL		
		155501	B. WING	·		04/07/2	011	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE			
			1529 W LANCASTER ST					
MEADOV	WVALE HEALTH AN	ID REHABILITATION CENTER		BLUFF	ΓΟΝ, IN46714			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	are within compliance at all tim	100	DATE	
	-	essible at all times.			to include: 1. The Maintenar			
	-	oractice could affect		Supervisor had a contractor come to the facility and adjust the				
		vacuated through						
	the 600 north h	nall exit in the event			magnets on the 600 hall egres	S		
	of an emergeno	cy.			door. 2. An audit of the exit discharge paths will be monito	red		
	Findings includ	Findings include:			by the Maintenance Superviso on a weekly basis to ensure resident safety. 3. The			
	Based on obser	vation with the			Maintenance Supervisor was			
	   Maintenance Di	irector and the			in-serviced on April 14, 2011 o Life Safety Tag K038 to ensure			
	Regional Facility Manager on 04/07/11 at 12:22 p.m.,				the exit discharge paths will	;		
					release after 15 seconds. 4.	An		
		sign on the 600			audit will be conducted by the			
	_	the magnetic lock			Maintenance Supervisor on a			
		er the crash bar is			weekly basis in order to ensure the discharge paths are	9		
	held for fifteen				accessible. It will also be			
					monitored through the facility's			
	magnetic lock did not release after the crash bar was held for forty				Performance Improvement			
	five seconds.	•			Program for further recommendations and			
		the Maintenance			resolutions.			
	Director at the							
	observation, he							
	=	the magnetic lock						
		and he was able to						
		ary fix until the fire						
		is contacted to						
	make the repai	r.						
	3.1-19(b)							
K0046		g of at least 1½ hour ed in accordance with 7.9.						
SS=C	Based on obser	vation and record	K00	046	K - 046 It is the practice of this	3	05/23/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155501 04/07/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1529 W LANCASTER ST MEADOWVALE HEALTH AND REHABILITATION CENTER BLUFFTON, IN46714 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE facility to assure that all review, the facility failed to ensure miscellaneous life safety issues 1 of 1 emergency lights was tested are within compliance at all times annually for at least a 1 1/2 hour to include: 1. The Maintenance duration in accordance with LSC Supervisor tested the emergency lights on April 4, 2011 for one and 7.9. LSC 7.9.3 Periodic Testing of one-half hour duration. 2. The **Emergency Lighting Equipment** Maintenance Supervisor will keep requires an annual test shall be a written record of a time and conducted on every required date in which the battery operated emergency light will be tested battery powered emergency light annually. 3. The Maintenance for not less than 1 1/2 hour Supervisor was in-serviced on duration. Equipment shall be fully April 14, 2011 on Life Safety Tag K046 to ensure the battery operational for the duration of the operated emergency lights will be test. Written records of visual tested annually. 4. An audit will inspections and tests shall be kept be conducted by the Maintenance by the owner for inspection by the Supervisor on an annual basis in order to ensure the battery authority having jurisdiction. This operated emergency lights are deficient practice could affect all fully operational. It will also be occupants. monitored through the facility's Performance Improvement Program for further Findings include: recommendations and resolutions. Based on observation with the Maintenance Director and the Regional Facility Manager on 04/07/11 at 1:30 p.m., a battery operated emergency light was observed at the generator. During record review with the Maintenance Director at 11:50 a.m., no written record of an annual test regarding the battery operated emergency light was available for review.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED		
		155501 B. WING			04/07/2011		
NAME OF PROVIDER OR SUPPLIER  MEADOWVALE HEALTH AND REHABILITATION CENTER				1529 W	DDRESS, CITY, STATE, ZIP CODE LANCASTER ST TON, IN46714		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	<del>                                     </del>	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0144	3.1–19(b)  Generators are ins	spected weekly and					
	exercised under lo month in accordar 3.4.4.1.	and for 30 minutes per name with NFPA 99.					
SS=F	Based on obser interview, the far ensure 1 of 1 e generators was remote manual requires emerg providing power lighting system tested and main accordance with Standard for Enstandby Power 110, 1999 edition, 1999 edition for a type similar station located housing the primary, Standard for and Use of State Engines and Garagines of 100 more have proving the primary of	acility failed to mergency equipped with a stop. LSC 7.9.2.3 ency generators er to emergency s shall be installed, ntained in h NFPA 110, nergency and Systems. NFPA ion, 3-5.5.6 I installations shall manual stop station er to a break-glass outside the room me mover. NFPA or the Installation ionary Combustion s Turbines, 1998 2(c) requires	K01	144	K – 144 It is the practice of this facility to assure that all miscellaneous life safety issue are within compliance at all tim to include: 1. The Maintenar Supervisor had a contractor co to the facility and evaluate the emergency generator for installation of a remote manual stop. 2. The Maintenance supervisor has made the necessary contact for the contractor to come out and ensure compliance by installing remote manual stop. 3. The Maintenance Supervisor was in-serviced on April 14, 2011 o Life Safety Tag K144 to ensure that the emergency generator would need a remote manual stop. 4. All necessary contracted work has been contracted; facility is waiting fo work to be accomplished.	s nes nce ome	05/23/2011

000465

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155501		(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  (X3) DATE SURVEY  COMPLETED  04/07/2011			
NAME OF PROVIDER OR SUPPLIER  MEADOWVALE HEALTH AND REHABILITATION CENTER			STREET A 1529 W	LANCASTER ST	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	from a remote deficient practi occupants.	location. This ce could affect all			
	Findings includ	e:			
	Maintenance D Facility Manage Director on 04, tour of the faci p.m. to 2:45 p. not have a rem the emergency on an interview Maintenance D	m., the facility did ote manual stop for generator. Based with the irector at 11:45 rator engine was			